WEA trust
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LONG TERM CARE CLAIM SUBMISSION FORM

Client/Patient/Member Name	
WEA Trust Group Number	
WEA Trust Subscriber ID Number	
Facility Name or Provider	

COMPLETE THE REQUIRED INFORMATION BELOW TO PREVENT A DELAY IN PROCESSING

What is the date of service range (first and last date of service) for the attached invoice?	_____/_____/_____ through _____/_____/_____ mm dd yyyy mm dd yyyy
Has the attached invoice been paid in full? **Please include proof of payment. Your claim cannot be processed without proof of payment.**	☐ YES ☐ NO
Has the service level changed since the last invoice? **If yes, please include an updated provider's care plan.**	☐ YES ☐ NO
FOR RESIDENTIAL CARE ONLY – At any time during the billing period, was the resident away from the facility overnight for any reason? **If yes, please provide dates of absence, reason for absence, and hospital admission and discharge date, if applicable.**	☐ YES ☐ NO **If yes, provide dates:** _____/_____/_____ through _____/_____/_____ Departure Date Return Date **Provide Reason for Absence**:_____ **If absence was due to a hospital stay, provide dates:** _____/_____/_____ through _____/_____/_____ Admission Date Discharge Date
Did Medicare or the VA provide benefits for any expenses incurred during the billing period? **If yes, please provide a copy of the Explanation of Medicare Benefits.**	☐ YES ☐ NO
Did the resident pass away during the billing period? **If yes, please provide the date of death.**	☐ YES ☐ NO **Date of Death** _____/_____/_____ mm dd yyyy

Please note:

*Eligible benefits are paid within 30 days after we receive a claim **AND** the proof of payment for a covered loss.*
Eligible benefits are never paid in advance of receiving a service.
Fees charged for copying and/or submitting required documentation are not eligible for reimbursement.

Acceptable forms of proof of payment include:

Copies of invoices marked as paid by the provider.
Copies of personal checks showing payment to the provider of care.